



Mental Health Parity and Addiction Equity Act (MHPAEA) Quick Guide

The following information is also available online at <http://mdpsych.org/advocacy-legislation/parity/>.
(*Designates document enclosed)

1. Parity Facts* and How Parity Implementation Can Help Psychiatrists*

Place copies of parity flyers in your waiting room.

- Fair Insurance Coverage: It's the Law* (Maryland-specific)
- Red Flags! Your health plan may be violating the law*
- Common Parity Violations*

Consider providing the Share Your Story form to patients who express interest.*



2. If it seems the MHPAEA has been violated, first be sure the law applies:

Which plans does the federal parity law apply to?

Plan	Does MHPAEA Apply
Employer-funded plans with more than 50 insured employees?	Yes
Medicaid managed-care plans	Yes
Children's Health Insurance Program plans	Yes
Medicaid Alternative Benefit plans (Medicaid expansion)	Yes
Non-grandfathered small employer plans (less than 51 employees)	Yes*
Non-grandfathered individual market plans	Yes**
Plans offered through the health insurance exchanges	Yes
Federal Employees Health Benefits Plans (FEHBP)	Yes***
TRICARE/DOD plans	No
Medicare plans	No
Veterans Administration	No
Short-duration health plans	No

* Technically MHPAEA does not apply directly to small group health plans, although its requirements are applied indirectly to non-grandfathered small group health plans in connection with the Affordable Care Act's (ACA) essential health benefit (EHB) requirements

**Non-grandfathered plans that came into existence after the enactment of the ACA on March 23, 2010

*** While the MHPAEA statute does not apply to Federal Employees Health Benefits Program (FEHBP), the Office of Personnel Management has issued carrier letters directing such plans to comply with MHPAEA



If parity applies, it is critical to understand and compare the insurance benefits, often using a summary plan description (SPD) or Benefit Booklet.

IMPORTANT

(over)

3. Decide whether the situation fits the parity violation parameters

Policies and coverage practices for behavioral health services cannot be more restrictive than policies and practices for medical or surgical services. Comparisons between behavioral and medical/surgical benefits are made according to the class of benefits, namely: Inpatient to inpatient, Outpatient to outpatient, In-network to in-network, Out-of-network to out-of-network, Emergency care to emergency care and Prescription drugs to prescription drugs.

Violations can take many forms. Some are measured by a dollar amount or a number; e.g., co-payments or deductibles and outpatient visits allowed each year. Others are more complicated "non-quantitative" limitations, such as preauthorization, likelihood of improvement, geographic, etc.

Use the *Red Flags** and *Common Violations** flyers and the *Warning Signs- NTQLs** and *Parity Compliance Problems** descriptions to help with identification.



4. Request a peer-to-peer review or file an internal appeal directly with the applicable insurer.

Sample appeal letters are available at <https://lac.org/parity-guide-sample-letters/> and <https://www.psychiatry.org/psychiatrists/practice/parity>.



5. If the appeal fails, file a complaint with the appropriate agency, which depends on the type of insurance coverage:

Insurance plans (purchased by employers, or by individuals)	Maryland Insurance Administration or Attorney General (How to File a Complaint in Maryland*)
Employer pays for coverage (Self-funded plan)	U.S. Department of Labor (https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/what-we-do)
Insurance through state/local government employers	U.S. Department of Health and Human Services (https://www.hhs.gov/regulations/complaints-and-appeals/index.html)



APA Parity Enforcement Resources: <https://www.psychiatry.org/psychiatrists/practice/parity>

Legal Action Center (LAC) publication, *Health Insurance for Addiction & Mental Health Care: A Guide to the Federal Parity Law* (106 pages) <https://lac.org/health-insurance-for-addiction-mental-health-care-a-guide-to-the-federal-parity-law/>

Parity at 10: <https://parityat10.org>

Parity Implementation Coalition: <https://parityispersonal.org/>

Parity Resource Guide for Addiction & Mental Health Consumers, Providers and Advocates
https://parityispersonal.org/media/documents/KennedyForum-ResourceGuide_FINAL_1.pdf
A 103-page in-depth review of the law, types of appeals, filing appeals and complaints, etc.

Parity Track: www.paritytrack.org

Parity Facts

The Law

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires equal coverage of mental health and substance use disorder benefits – both as written in health plans and as delivered in practice – with other medical care.
- The Affordable Care Act extended the Parity Act by guaranteeing insurance coverage for persons with pre-existing mental health and substance use disorders and by requiring coverage of mental health and substance use disorder benefits as an essential health benefit at parity with other medical benefits.
- Maryland has its own state parity legislation that requires coverage of a continuum of mental health and substance use disorder services, including medication assisted treatment and residential care, in compliance with the federal Parity Act.

Still, too many Marylanders do not receive equitable coverage for these prevalent disorders:

- Maryland has experienced a 119% increase in deaths from drug intoxication over three years due to opioid overdose.
- Suicide rates in Maryland increased by 14% from 2012 to 2017.
- Nearly 70% of individuals confined in Maryland jails have a substance use disorder and nearly 40% have a mental health disorders, most of whom (89%) also have a substance use disorder.

Marylanders with employer-based health insurance pay higher out-of-pocket costs for mental health and substance use disorder care than for other medical services because health plan networks are inadequate, and mental health and substance use disorder providers are reimbursed at lower levels than other medical providers.

The Maryland Insurance Administration and Maryland Department of Health have taken important steps to enforce federal and state parity laws. However, many trouble spots remain related to **how insurers design and apply their managed care practices**, such as prior authorization requirements, step therapy, and requirements for providers to join an insurer's network. Often, insurers design and apply these managed care techniques in ways that are **more restrictive for mental health and substance use disorder treatment** than for other medical treatment, which violates the Federal Parity Law.

HOW PARITY IMPLEMENTATION CAN HELP PSYCHIATRISTS

The federal Mental Health Parity and Addiction Equity Act (MHPAEA) requires insurance coverage for mental health and substance use disorder care to be no more restrictive than coverage for other medical care. Unfortunately, even though it has existed for a decade, insurers are still not in full compliance with the law. Better enforcement efforts by state insurance departments and state Medicaid agencies are essential to securing full compliance.

Insurers are largely in compliance with the more straightforward aspects of parity, such as eliminating more restrictive inpatient day limits and cost sharing requirements for mental health care. However, there is still noncompliance in the more complex areas relating to insurers' managed care practices. Here are some of the most problematic issues:

- Prior authorization and other types of utilization review are performed more stringently for mental health care than other medical care
- Reimbursement rates for mental health services are designed in a way that likely runs afoul of MHPAEA's rules
- The way in which insurers establish and maintain their networks of mental health providers is not comparable to how they do so for other medical providers
- Insurers categorically decide to exclude from coverage certain clinically-appropriate treatments for common mental disorders in a fashion that is not comparable to how they decide whether to cover clinically-appropriate treatments for common medical conditions

These problems will not abate without stronger oversight from state regulatory bodies. However, enhanced but targeted enforcement will correct insurers' behavior. **This will benefit psychiatrists in the following ways:**

- Reduce the administrative burden encountered during utilization review
- Increase reimbursement rates so that accepting insurance is a viable option
- Lead insurers to design and maintain their mental health provider networks in a way that incentivizes participation
- Enhance the range of treatment modalities available to patients

Fair Insurance Coverage: **IT'S THE LAW**

Federal law prohibits your private health insurance plan from discriminating against you because you have a mental illness, including a substance use disorder. Coverage for a mental health concern now must be equivalent to coverage for physical health problems, like heart disease, diabetes and cancer.

Under the federal “Mental Health Parity” law:

- 1** You are entitled to the treatment your physician says is necessary for your mental health or substance use disorder. Your health plan cannot require you to fail first at less-expensive treatments if it does not have the same “fail first” requirement on all other illnesses covered by your plan.
- 2** With few exceptions your co-payment or co-insurance for your mental health benefit should not be higher than it is for other medical care, and you should have only one deductible and out-of-pocket maximum that covers all of your health care.
- 3** When you visit a psychiatrist for medication management and for psychotherapy on the same day, you should pay only one co-payment.
- 4** You should have access to an “in network” mental health provider who:
 - is qualified to treat your condition
 - can see you in a reasonable amount of time at a location accessible from your home.
- 5** Mental health-related visits or treatment should not require pre-authorization, unless your plan requires pre-authorization for most other medical care.
- 6** The number of visits or hospital days should not be limited, unless similar limitations apply to most other medical illnesses under your plan.
- 7** Your health plan should pay even if you don’t complete the treatment or a prior recommended course of treatment.
- 8** Your health plan is required to provide you with a written explanation of:
 - how it evaluated your need for treatment
 - why it denied the claim
 - the basis for its conclusion that the plan complies with federal law.
- 9** You have the right to appeal your plan’s decision about your care or coverage. You have the right to appeal the claim with your plan and **The Maryland Insurance Administration** ([www.http://www.mdinsurance.state.md.us/sa/consumer/appeals-and-grievances.html](http://www.mdinsurance.state.md.us/sa/consumer/appeals-and-grievances.html))
- 10** If you have an out-of-network benefit in your plan and see an out-of-network psychiatrist, the health plan should reimburse you for a portion of the amount you paid for the visit. If the amount you are reimbursed is significantly less than the amount the health plan pays to other doctors who are out-of-network, this may be illegal. You can see what doctors are paid by checking the explanation of benefits you receive from your plan.

If you have concerns about your health plan’s compliance with federal law:

- **The Maryland Insurance Administration** • 410-468-2000 or 800-492-6116 • www.mdinsurance.state.md.us
- **Maryland Parity Project** • 443-901-1550 x206 • www.mhamd.org or www.marylandparity.org
- **MPS - Maryland Psychiatric Society** • 410-625-0232 • www.mdpsych.org
- **Health Education & Advocacy Unit - Maryland Attorney General** 410-528-1840 or 800-261-8807 www.oag.state.md.us
- Go to the **U.S. Department of Health and Human Services Mental Health and Substance Use Disorder Parity** and report your problem: <https://www.hhs.gov/programs/topic-sites/mental-health-parity/index.html>



Common Parity Violations



What is Parity?

The Mental Health Parity and Addiction Equity Act of 2008, also known as the Federal Parity Law, requires insurers to cover illnesses of the brain, such as depression or addiction, no more restrictively than illnesses of the body, such as diabetes or cancer. Some states model promising policies for monitoring and enforcing insurer adherence to this law that other states can consider implementing.

1 Insurer requires patient to pay a separate deductible or higher co-pays for behavioral health services.



2 Insurer sets limits on how many days a patient can stay in a treatment facility or how many times they can see a behavioral health provider.



3 Insurer charges more for prescription medication for behavioral health treatment.

4 Insurer makes patient get permission before starting and/or continuing behavioral health treatment.



5 Insurer forces patient to try a less expensive treatment before pursuing treatment recommended by a doctor.



6 Insurer refuses to pay for residential behavioral health treatment recommended by a doctor.



7 Insurer refuses to pay for behavioral health treatment outside of patient's state or region.



If you have been denied coverage for mental health or addiction treatment services, your rights may have been violated. Visit ParityRegistry.org to learn how to file an appeal with your health plan, send a complaint directly to state enforcement officials, find state and federal regulators who can help with an appeal, and more.

RED FLAGS!

Your health plan may be violating the law

State and federal parity laws require most health insurance plans (private and Medicaid) to cover substance use disorder (SUD) and mental health (MH) benefits equally with other medical and surgical benefits. But many do not. If your health plan does anything listed here, it may be violating the law if it does not place similar limits on medical services.

Authorization and Medical Necessity Decisions

- Requires pre-authorization or pre-notification for all SUD or MH services.
- Requires frequent continuing care review for SUD or MH services or medications, approving only a few days of services before requiring another authorization.
- Requires patients to “fail first” at a lower level of SUD or MH care (like outpatient) before approving a higher level of care (like inpatient).
- Refuses to cover a course of treatment because patient “failed to complete previous treatment,” “is not improving,” or “is not likely to improve.”
- Only covers services that result in a measurable and substantial improvement in mental health status within a certain number of days.
- Requires a written treatment plan for SUD or MH services earlier in the treatment process or more frequently than for medical services.

What should you do if you see a red flag?

Notify state and federal regulators. They look to consumer and provider complaints to identify and fix parity violations. For more information, please read *Has Your Health Insurer Delayed or Denied Substance Use or Mental Health Care?* at www.lac.org/redflagcompanion. For sample complaints and even more in-depth information, please read *Health Insurance for Addiction and Mental Health Care: A Guide to the Federal Parity Law*, available at www.lac.org/parityguide.

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www.lac.org

Provider Network and Reimbursement

- Has no or very limited network providers for SUD or MH services.
- Has no in-network SUD or MH providers accepting new patients or within a reasonable distance.
- Requires SUD and MH providers to have additional documentation or qualifications for network admission than it has for medical providers.
- Reimburses SUD and MH care providers at rates lower than medical providers billing for same services.
- Sets SUD and MH reimbursement rates using different standards than it uses for medical providers.

Benefit Exclusions and Limits on Care

- Does not cover residential SUD or MH care.
- Does not cover SUD medications (e.g., methadone treatment, buprenorphine, naltrexone, or naloxone) or limits length of coverage.
- Limits the number of days or visits for SUD or MH care.

Different Out-Of-Pocket Costs

- Charges higher co-payments for routine substance use disorder or mental health visits than for routine medical and surgical visits.
- Charges a separate deductible for substance use disorder or mental health services.
- Limits how much it will pay per year, or during a patient's lifetime, for substance use disorder or mental health services.

Other Barriers to Care

- Places geographic limitations on where a patient can receive SUD or MH services (for example, not covering services received out-of-state) without similar limitations for medical services.
- Provides insufficient or incorrect information in service denial letters.
- Refuses to provide information, like medical necessity criteria and documents explaining plan standards, when patients or providers request it.



Share Your Story: Accessing Mental Health/Substance Use Disorder Treatment Through Your Insurance

The Mental Health Parity and Addiction Equity Act (Parity Act) was enacted a decade ago to prevent discriminatory insurance coverage for mental health and substance use disorder services. Today, too many people still cannot get the treatment they need because their insurer still uses discriminatory rules. Better enforcement of the Parity Act can help you and others get the services that insurers are required to cover. By sharing your experience with insurance problems, you can help us advocate for better enforcement of the Parity Act and improved access to treatment. You can access this form, with the additional option to submit photographs, videos and other media, online at <https://parityat10.org/the-issue/#shareyourstory>.

Here are some of the insurance problems you may have experienced:

- Your insurer said a treatment service was not “medically necessary.”
- Your insurer required you to get prior approval for a service that delayed treatment.
- Your insurer told you to try a less expensive service or medication before it approved the service or medication your provider recommended.
- You could not find a treatment provider in your insurer’s network.

Name (First and Last):	
Email Address:	
Phone Number:	
State/Zip Code:	

Please share your experience with insurance delay or denials below. We have identified a few questions to guide your response, but you should feel welcome to share whatever you think is important. Your experience will help to inform our advocacy work, and we thank you for taking the time to share it!

Who were you seeking treatment for (yourself, son, daughter, spouse, other family member, or friend) and was that person a minor or an adult at the time?



IT'S THE LAW.

What treatment services did you seek coverage for?

--

Identify any problems you had finding a treatment provider or getting into care quickly.

--

Describe your experience in getting your insurer to approve or pay for your treatment services.

--



IT'S THE LAW.

If you had problems with your insurance coverage, please describe the impact on you or your family (financial situation, health of the person needing treatment and other family members, personal or family stress).

--

How are you and/or your loved one is doing today?

--

Is there anything else about your experience that you'd like to share?

--



Scope of Use

Thank you for sharing your story. Your story matters and can help to change the system. The following details are important.

Please let us know how you would like to be identified:

- My first and last name
- My first name only
- A pseudonym/remain anonymous

Scope of Use:

- I consent to Parity at 10 utilizing my story in **all** the following ways:
 - On the Parity at 10 website (www.parityat10.org)
 - In social media messages pertaining to the Parity at 10 Campaign and/or
 - In printed materials produced by the Parity at 10 Campaign to education policy-makers, healthcare providers and other families/consumers

We would like to stay in touch with you as there may be additional opportunities to share your story beyond the previously mentioned outlets. Please let us know what interests you. (Select all that apply):

- I am interested in participating in meeting with state policy-makers about my insurance experience.
- I would consider speaking to the media about my experience (note, we will contact you to present the media opportunity and to affirm your willingness prior to connecting you with the journalist).
- Parity at 10 may contact me if they seek to use my story in an additional way not indicated above.

Permission:

- I hereby give permission for the Parity at 10 Campaign to use, publish, and condense the testimonial and/or media uploaded I have provided. I hereby release, discharge, and agree to hold harmless the Parity at 10 campaign from any liability relating to the publication of my testimonial except if it is used in a way that is inconsistent with what is outlined above.

Signature: _____

Date: _____

[FOR MINORS ONLY]: If you are under 18 years of age, your parent or legal guardian must sign this Consent and Release Form and provide the information requested below:

- I certify that I am the parent or legal guardian of the person listed above and I agree that I have read this form completely and I understand the contents of this form.

Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance



The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage¹ ensure that the financial requirements and treatment limitations on Mental Health or Substance Use Disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical (med/surg) benefits. This is commonly referred to as providing MH/SUD benefits in parity with med/surg benefits.

There are requirements for determining parity with respect to financial requirements (such as copays) and for treatment limitations, which limit the scope or duration of benefits for treatment. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements).² The rules for financial requirements and QTLs are different from the rules for NQTLs. This publication focuses on NQTLs and how to identify provisions that will require inquiry beyond the plan/policy terms in order to determine compliance with mental health parity requirements.

Under MHPAEA regulations, a plan or issuer may not impose an NQTL on MH/SUD benefits unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification³ are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to med/surg benefits in the same classification. Federal MHPAEA regulations contain an illustrative, non-exhaustive list of NQTLs,⁴ which include:

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
- formulary design for prescription drugs;
- network tier design;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- fail-first policies or step therapy protocols;
- exclusions based on failure to complete a course of treatment; and
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Stakeholders have asked for examples of plan provisions they might see on the MH/SUD side which should trigger careful analysis of the coverage on the med/surg side in order to ensure MHPAEA NQTL compliance.

¹ MHPAEA contains an exemption for small employers (generally those with 50 or fewer employees), as well as plans that meet an increased cost exemption. The Affordable Care Act extended MHPAEA to individual coverage and HHS's essential health benefits regulations require non-grandfathered individual and small group coverage to ensure parity as an EHB requirement. Retiree health plans continue to be exempt.

² See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.

³ The classifications are inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; prescription drugs and emergency care. Sub-classifications for outpatient office visits and network tiering are permissible. 26 CFR 54.9812-1(c)(2)(ii), (3)(iii); 29 CFR 2590.712(c)(2)(ii), (3)(iii); 45 CFR 146.136(c)(2)(ii), (3)(iii); and 147.160.

⁴ 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii); and 147.160.

Language contained in the following provisions (absent similar restrictions on med/surg benefits) can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL. Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both MH/SUD and med/surg benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance. The categories and examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance issued by the Departments.

EXAMPLE PROVISIONS: If you see these types of plan or policy provisions, investigate if these types of limits are also applied to med/surg benefits and if so, if they are being applied to MH/SUD and med/surg benefits in a manner that complies with MHPAEA.

I. Preauthorization & Pre-service Notification Requirements

- **Blanket Preauthorization Requirement:** Plan/insurer requires preauthorization for all mental health and substance use disorder services.
- **Treatment Facility Admission Preauthorization:** Plan/policy states that if the insured is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, insured will be responsible for the cost of services received.

Plan states that for inpatient mental health precertification is required.

Plan requires pre-notification or notification ASAP for non-scheduled MH/SUD admissions and reduces benefits 50% if pre-notification is not received.

Plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.

Plan requires preauthorization or concurrent care review every 10 days for MH/SUD services but not for med/surg services.

- **Medical Necessity Review Authority:** Plan's/insurer's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for med/surg services but conducts its own reviews for MH/SUD services.
- **Prescription Drug Preauthorization:** Plan/insurer requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.
- **Extensive Pre-notification Requirements:** Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.

II. Fail-first Protocols

- **Progress Requirements:** For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.

- ***Treatment Attempt Requirements:*** For inpatient SUD rehabilitation treatment plan/insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.

For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.

III. Probability of Improvement

- ***Likelihood of Improvement:*** For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement.

Plan/policy only covers services that result in measurable and substantial improvement in mental health status within 90 days.

IV. Written Treatment Plan Required

- ***Written Treatment Plan:*** For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.
- ***Treatment Plan Required within a Certain Time Period:*** Plan/insurer requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation. Plan needs to be reviewed at least once a week for progress.
- ***Treatment Plan Submission on a Regular Basis:*** Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months.

V. Other

- ***Patient Non-compliance:*** Plan/policy excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.
- ***Residential Treatment Limits:*** Plan/policy excludes residential level of treatment for chemical dependency.
- ***Geographical Limitations:*** Plan/policy imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on med/surg benefits.
- ***Licensure Requirements:*** Plan/policy requires that MH/SUD facilities be licensed by a State but does not impose the same requirement on med/surg facilities.

Parity Compliance Problems

1. Higher costs or fewer visits for mental health services than for other kinds of health care.
2. Having to call for permission to get mental health care covered, but not for other types of care.
3. Getting denied mental health services because they were not considered “medically necessary,” but the plan does not answer a request for the medical necessity criteria they use.
4. Inability to find any in-network mental health providers that are taking new patients but can for other health care.
5. The plan will not cover residential mental health or substance use treatment or intensive outpatient care, but they do for other health conditions.

(See also <https://parityispersonal.org/answers/background/common-compliance-problems> and Part IV of the [Parity Resource Guide](#).)

Disclosure of criteria: There is a lack of disclosure by plans of their medical management criteria and information on how they apply medical management techniques to medical/surgical benefits as compared to mental health/substance use disorder (MH/SUD) benefits. To date, few plans provide criteria beyond what is available on their website and no plans have disclosed any details of how they apply non-quantitative treatment limits (NQTLs) to medical versus behavioral treatment services. Plans continue to respond to such disclosure requests with generic statements lacking specificity; asserting the “proprietary” nature of the criteria used; or not responding at all. Plans continue to not respond to disclosure requests for medical/surgical criteria with a referral to their website or no response at all. Plans are also not providing information with respect to how criteria are applied. It is impossible to enforce the parity law without being able to compare the application of NQTLs.

Network Adequacy: Plans generally have fewer providers in their MH/SUD networks than they do in their medical/surgical networks, and consequently, a higher percentage of MH/SUD patients are treated by out-of-network providers as compared to medical/surgical patients. One of the factors that can be attributed to a lack of network adequacy is that physicians and other providers are generally paid lower reimbursement rates than medical/surgical providers, despite MHPAEA requiring parity regarding the same. MH/SUD facilities are also generally reimbursed at lower rates.

Facility-type/Level of care restrictions: Plans generally impose more restrictive limitations and exclusions on facility-types and clinically recognized levels of care for MH/SUD benefits than are imposed on medical/surgical benefits (Notably, non-hospital based residential treatment for SUDs). Plans continue to exclude non-hospital-based substance use disorder facilities from benefit coverage, while covering skilled nursing facilities and rehabilitation facilities under the medical benefit. Plans also continue to exclude clinically recognized levels of care such as partial hospitalization and residential treatment under the behavioral health benefit, while covering comparable levels of skilled nursing care, and inpatient and outpatient rehabilitative care under the medical/surgical benefit.

Lack of Parity in Pre-authorization: Plans generally have more stringent medical management techniques (i.e., pre-authorization and concurrent review requirements, medical necessity reviews, etc.) that are applied to MH/SUD services than to medical/surgical services. Some plans are requiring that their medical directors conduct SUD medical necessity reviews, while care managers continue to conduct reviews on the medical/surgical side.

External review/appeal process: Current guidance significantly limits the external review process to plan determinations involving medical judgment and to rescissions. “Determinations involving medical judgment” do not include many administrative benefit coverage denials that may violate and undermine the parity law, such as the proscribed use of preauthorization for outpatient psychotherapy or blanket exclusions of medically necessary care (that violate the parity statute) for covered conditions or blanket experimental/investigational exclusions of services for covered conditions based on internal Third Party Administrator (TPA) standards that violate plan language. Current guidance also permits self-insured plans to choose the Independent Review Organizations (IROs) with which they contract, inevitably reducing the opportunity for fair and impartial review. No third-party oversight exists of IROs in the self-funded (ERISA) context, who routinely fail to forward TPA-supplied documents for review by claimants prior to adjudicating appeals, fail to directly notice claimants (rather than contracted TPAs) of their determinations, even in urgent cases, and fail to publicly disclose their medical necessity criteria prior to adjudicating external appeals.

How to file a Complaint in Maryland

The Mental Health Parity and Addiction Equity Act (MHPAEA) and some state laws allow insured individuals or their providers to challenge a coverage determination if the plan does not cover the same level or scope of services for mental health/substance use disorders as the plan covers for medical/surgical conditions. A parity appeal of denied or limited services may be based upon the insurer's determination that the behavioral services requested are not medically necessary or are not a covered service under the benefit plan if those coverages are available for medical/surgical services under the same plan.

Patients and psychiatrists are encouraged to file a complaint if a carrier denies coverage and peer-to-peer fails, or if the peer-to-peer resolution is not satisfactory.

The Health Education and Advocacy Unit of the Maryland Attorney General's Office (HEAU) can assist with filing an appeal through the carrier's internal process, or with filing a complaint with the Maryland Insurance Administration (MIA) or other external reviewer. If it is an emergency and care has not been provided yet, a complaint can be filed without first going through the carrier's process.

Maryland Attorney General's Health Education and Advocacy Unit

Please go to <http://www.marylandattorneygeneral.gov/Pages/CPD/HEAU/default.aspx> and refer to the [patient information sheet](#), review the [provider filing information](#), and [click here](#) or choose an HEAU online complaint form.

For assistance by phone, call toll free 877-261-8807.
Send requests by email to heau@oag.state.md.us.

Maryland Insurance Administration

Visit <http://www.mdinsurance.state.md.us/Consumer/pages/HealthCoverage.aspx> to find out what to do if a carrier [denies an emergency inpatient admission](#); review how the MIA assists with [denials involving opioid use](#) disorder; and read the MIA consumer [guide to mental health and substance use coverage](#). The guide addresses steps to take in the [appeals and grievance](#) process, which is online at <https://insurance.maryland.gov/Consumer/Pages/FileAComplaint.aspx>.

For MIA assistance by phone, call toll free 800-492-6116.
For questions or concerns regarding MHPAEA, contact Darci M. Smith, J.D., Special Assistant, MHPAEA at 410-468-2299 or darci.smith@maryland.gov.

In addition, the [Parity Resource Guide](#) has step-by-step information that can help you file an appeal. Other options for action are in the [Red Flags companion](#).